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ABSTRACT

Mental health services are often unavailable, inaccessible, or inappropriate for the children and families who need them. In order to implement a more effective system of mental health services to children and adolescents, an adequate system of care must be defined and described, and a policy mandate to implement such a system must be developed. As part of a continuing program of research on mental health policy for children and adolescents, a study in one state was conducted which involved: (1) a survey of all community mental health centers; (2) a compilation of data from the state's management information system; and (3) in-depth interviews with stakeholders in the mental health system. Key figures (N=49) in the development of the state's mental health system over the last 30 years and 18 additional current stakeholders in the state's mental health system were interviewed within a qualitative research framework. The interview data showed that the major factors influencing policy development and implementation were economic and political, not scientific and professional as traditional viewpoints might suggest. These results support the view that the traditional treatment-oriented and positivist-empiricist approach is inadequate for studying, understanding, or influencing mental health policy. Needed is a focus on the economics and politics of the policy implementation process, including value considerations (in addition to traditional study of the treatment process) and the use of qualitative methods to complement the positivist-empiricist approaches most widely used in policy analysis and progam evaluation. (A six-page bibliography and two data tables are included.) (Author/NRB)

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The Use of Mental Health Standards in Child and Adolescent Programs: What Factors Influence Policy Development and Implementation?

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Abstract

Although psychologists are increasingly paying attention to mental health policy, this field entails a social reality that is out of phase with many traditional clinical and research methods. The development of community mental health center service standards for children and adolescents served as the context and the stimulus for exploring alternative frameworks for conceptualizing and studying the policy process. Interview data from mental health system stakeholders in one state showed that the major factors influencing policy development and implementation were economic and political, not scientific and professional as traditional viewpoints might have us believe. It was concluded that the traditional treatment-oriented and positivist-empiricist approach is inadequate for studying, understanding, or influencing mental health policy. Needed is a focus on the economics and politics of the policy implementation process, including value considerations -- in addition to traditional study of the treatment process -- and the use of qualitative methods to complement the positivist-empiricist approaches most widely used in policy analysis and program evaluation.

The Use of Mental Health Standards in Child and Adolescent Programs: What Factors Influence Policy Development and Implementation?

> Scholars are of all men those least fitted for politics and its ways. The reason for this is that they are accustomed to intellectual speculation, the search for concepts and their abstraction from sense-data . . . they do not, in general, seek to make their thoughts conform to external reality, but rather deduce what ought to exist outside from what goes on in their minds.
>
> Now those who engage in politics must pay great attention to what goes on outside, and to all the circumstances that accompany and succeed an event. Hence men of learning, who are accustomed to generalizations and the extensive use of analogy, tend, when dealing with political affairs, to impose their own frame of concepts and deductions on things, thus falling into error.
>
> Ibn Khaldun
> The Muqaddimah
> (cited in Allison, 1984)

Psychologists are increasingly paying attention to mental health policy as a field for inquiry and professional activity (Kiesler, 1980; Knitzer, 1984; Murrell, 1984; Sarason, 1984). This field, however, entails a social reality that is out of phase with many traditional clinical and research methods. In this paper, we present and offer supportive evidence for a framework--growing from an attempt to develop and implement statewide child and adolescent mental health standards--intended to help psychologists better understand and study the many facets of mental health policy.

The Received View

Theories of intervention, clinical research, and program evaluation are among the longstanding mental health policy-related interests of psychologists. Each of these activities typically entails a positivist-empiricist philosophy of science (Buss, 1975), which stresses (a) the preeminence of objective fact, (b) the demand for empirical testing of theory, (c) the assumption of temporal irrelevance of theory and data, and (d) the value-neutral role of the observer (Gergen, 1978). When psychologists apply this philosophy to the study of mental health policy, they typically view the policy process as (a) relying on objective fact as the coin of the realm, (b) using empirical feedback from formal evaluation procedures to correct prevailing policies, (c) entailing generalizable (as to time and place) intervention principles and strategies, and (d) capable of being separated from the values and personal biases of both the inquirer and the policy maker. Examples of such application include the management-by-objectives approach (Varney, 1979), used in both policy research and policy planning, which stresses goal setting, measurable objectives, and empirical feedback; and cost-effectiveness analysis (Levin, 1975; Rothenberg, 1975), so prevelant in policy analysis, which seeks a discoverable, objective basis for calculating costs and benefits of prescribed interventions.

Research and research-related methods are, presumably, the sine qua non for policy formulation and evaluation (Guba & Lincoln, 1981; Leviton & Hughes, 1981; Weiss, 1973). Psychologists avidly propose theoretically sound and well-researched mental health interventions and standards for policy consideration. The "best" intervention strategy, determined by scientific

criteria, is, presumably, the best and most obvious choice for policy makers.

Psychologists who have operated on these positivist-empiricist principles in the mental health policy arena, however, have often been disappointed and frustrated. Mental health interventions and standards rich in theory and research-proven effectiveness have either not typically been adopted, or if adopted, not successfully or faithfully implemented. Two intervention program examples among many include the Fairweather Lodge for the community treatment of chronic mental patients (Fairweather, 1980; Fairweather, Sanders, & Tornatzky, 1974; Fairweather & Tornatzky, 1977) and Project Re-ED for the ecologically-oriented treatment of emotionally disturbed children (Hobbs, 1979, 1982). There is a growing literature describing the nonutilization of research knowledge in the policy process (Dokecki, 1982, in press; Lindblom & Cohen, 1979; Lynn, 1978; Weiss, 1983).

An Alternative View

Perhaps psychologists in the policy arena are becoming alienated because they operate in a world separate and distinct from that of policy makers, as suggested in the opening quotation. For example, Caplan, Morrison, and Stambaugh (1975) developed and presented evidence for a "two communities theory," which described social science and social policy as separate cultures, holding distinct beliefs. In a similar vein, Rein and White (1977) maintained that social scientists' rational, problem-solving view of the policy process is a myth. (Interestingly, March (1984) has maintained that the prevailing view that organizations operate according to rational, problem-solving principles is also a

myth.) Rein and White also maintained that, rather than being context- and value-free, as the positivist-empiricist position would have us believe, social policy is a decidedly value-laden endeavor. The nonutilization of research knowledge in policy, then, may entail an incompatibility of world views, and, moreover, the positivist-empiricist world view may neither fully serve nor capture the dynamics of the policy process.

The March (1984) observation about organizations made parenthetically in the last paragraph may provide a lead to finding a corrective to the still prevailing positivist-empiricist mind set we have been describing. One approach to understanding the phenomenon of nonutilization of research knowledge is to explore the growing body of theory and research in organizations as it relates to the organizational settings in which policies and standards are developed and implemented. The traditional approach, belied by March's observation, has assumed a rational hierarchical approach to organizational planning and decision making. This approach has been called the structural (Bolman & Deal, 1984) or the systems management model (Elmore, 1978). There are other models that may better explain the social policy process, be it policy planning or implementation. These include the bureaucratic, human resource or organizational development, political or conflict and bargaining, and symbolic models. These models are useful in beginning to look beyond the positivist-empiricist approach.

Beyond organizational theory, there has been a growing discontent with the exclusive use of the positivist-empiricist method in psychology and the social sciences in general. Sampson (1978), among others (e.g., Gergen, 1978; Sarason, 1984; Seidman, 1983), has recommended adoption of an alternative set of

principles and assumptions. The importance of context (Sarbin, 1977), values (Howard, 1985), and the transactional role of the inquirer (Plas & Dokecki, 1982) have tended to be neglected in what Sampson called the Paradigm I approach of positivism. An alternative approach, Paradigm II, is required in which knowledge is seen as "historically generated and historically rooted" (Sampson, 1978, p. 1334), dynamic, and value-laden. The Paradigm II view of social problems and policy interventions entails considerations of social history and political and economic factors (Dokecki & Mashburn, 1984; Levine & Levine, 1970; Sarason, 1984), instead of (or in addition to) Paradigm I's focus on treatment and technology. In a related vein, Shadish (1984) has described the discrepancy between social science solutions (Paradigm I) and social system solutions (similar to Paradigm II). Social science solutions entail theoretically and empirically sound interventions, but they are not often successfully implemented in the policy process; social system solutions reflect the ideologies, values, and extant structures of the social reality of the policy and service systems, and they are more often implemented.

It is important to note that, even if they were successful, Paradigm I social science solutions can be effectively challenged on their claimed value neutrality: They have their own ideological base (Habermas, 1971). While professing objectivity, psychologists and other social scientists promote certain politically and economically tinged values in the very theories and research methods they employ (Sampson, 1978). These values, observed Shadish (1984), are often incompatible with those of the worlds of policy and service delivery, resulting in the nonutilization phenomenon we have been discussing and the too

prevalent failure to implement "model" programs. Ironically, it seems to require the willingness to consider Paradigm II assumptions in order to recognize the value-ladeness that so many historians and philosophers of science have claimed to be characteristic of Paradigm I. Anticipating our full argument for a moment, we do not suggest that Paradigm II replace Paradigm I in psychology in general or in the field of mental health policy in particular. Our argument emerges, based in part on the data presented later, as a call for the mitigation of the prevailing Paradigm I with the less traditional Paradigm II approach.

The Present Study

The development of mental health policy for children and adolescents, specifically the issue of service standards for community mental health centers, served as the context and the stimulus for the ideas we have been exploring thus far in this paper. The unmet needs of millions of disturbed children in the United States have been of concern for at least the last 15 years (Joint Commission, 1969; President's Commission, 1978). Mental health services are, in large part, unavailable, inaccessible, or inappropriate for the majority of children and families who need or request them (Goldsmith, 1977; Knitzer, 1982), a situation exacerbated by the current administration's policies, especially the budget reconciliation legislation. The systems that do provide mental health services to children vary markedly in structure from state to state, but can generally be characterized as (a) oriented towards crisis intervention and treatment to the detriment of prevention and early intervention services, (b) accessible primarily to those with private or public third-party payment, and (c)

leaning toward the more restrictive types of intervention such as residential treatment in a hospital-like setting (Albee, 1982; Kiesler, 1980; Knitzer, 1982).

The overarching policy question is obvious: How can we implement a more effective system of mental health services to children and adolescents? This requires (a) defining and describing an adequate system of care, and (b) developing a policy mandate to implement such a system. The solution, however, is not so obvious. The Paradigm I policy logic seems straight forward: Define the services that are needed and cost-effective; then write mental health standards to regulate the delivery of such services. This has been a typical response of state agencies to a perceived gap in service delivery. This logic implies the rational, fact-finding, problem-solving, treatment-focused approach familiar to psychologists and prescribes a task that we presumably can accomplish, an opportunity for social science knowledge to define policy. The logic, however, may not describe what is really at stake, and attending only to the treatment side of policy may not alter mental health services for children and adolescents at all.

This study was conducted in order to explore the applicability of Paradigm I and II assumptions to the study of mental health policy for children and adolescents. One particular state was studied as a case illustrating the dynamics underlying such policy.

Method

The present study is one part of a continuing program of research on mental health policy for children and adolescents. In order to do justice to this

complex topic, a multifacited method was used. At the national level, methods included a review of the policy and research literature and a survey of state departments of mental health. In one particular state, there were: (a) a survey of all its community mental health centers, (b) a compilation of data from the state's management information system, and (c) in depth interviews with stakeholders in the mental health system. In this paper, we focus on this last state-level interview data base.

The interviews were conducted in two phases within a qualitative research framework. During 1983 and 1984, 49 key figures in the development of the state's mental health system over the last 30 years were interviewed. They included former and present members of the state's mental health department, from the level of the commissioners and their advisors and staffs, to individuals responsible for policy implementation and monitoring. Also interviewed in this first phase were state executives in areas related to mental health, administrators in state mental health institutional programs and community mental health centers, state legislators, and the directors of professional associations and advocacy groups.

Based in part on findings from this first phase, 18 additional current stakeholders in the state's mental health system were selected and interviewed in the second phase. These included mental health department executives, middle managers, and advisors; and administrators, service coordinators, and providers in the state's mental health institutions and community mental health centers. Beyond those interviewed in the central departmental offices, an effort was made to get some representation from the major regions of the state and from both

urban and rural communities. As well, people were sought with particular knowledge and experience in the area of services for children and adolescents.

It should be stressed and readily apparent that those interviewed in both phases of the study constituted a highly select sample. In the first phase, which was concerned with identifying the most important factors that operated over the last 30 years in shaping the state's mental health system, the most visible and important people were identified, yielding a decidedly "top down" view of the situation. In the second phase, which focused on further exploration of important policy factors over the last five years and concentrated on the topic of policies, standards, and services for children and adolescents, some of the same kinds of people were interviewed, as well as a select sample of people working near or at the point of direct contact with clients. Although closer to a "bottom up" perspective than phase one, this outlook still must be considered to be select, albeit highly informed, and it was the highly informed perspective we were seeking throughout this study.

The research and analytic strategy entailed (a) transcribing the 49 interviews from the first phase, (b) identifying and coding those factors mentioned by respondents that had led to certain changes or had identifiable effects in the mental health system over the last 30 years, (c) interviewing the respondents in the second phase to determine the operation of phase one factors in the contemporary (1981-1985) child and adolescent service system, and (d) using phase two information somewhat informally to probe and illustrate the current scene. (More systematic analysis of phase two interviews are being performed in conjunction with analyses of the other sources of data from our

larger program of research, and all these data will be available in subsequent reports.)

The categories of factors influencing policy development and implementation were derived both from our knowledge of the policy process and literature and from inspection of the initial 49 phase one interviews. The following factors were eventually coded: (a) Economic--funding and budgetary matters; (b) Political--political issues related to government and professional concerns; (c) Leadership--reflecting the influence of certain individuals in leadership roles; (d) Values--individual or societal values related to humanitarian concerns; (e) Organizational--pertaining to the structure of the state mental health department or the mental health system in general; (f) Legal--judicial, statutory, or regulatory factors; (g) Scientific/Professional--referring to specific technological factors or research and professional knowledge.

Results and Discussion

Quantitative results are presented for phase one in Tables 1 and 2. It should be remembered that stakeholders (N=49) were interviewed about factors

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Insert Tables 1 and 2 about here

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that influenced general mental health policy development and implementation in the state's mental health system over the last 30 years. Where appropriate, data from phase two (N=18) are mentioned in order to explore the factors that have particularly influenced policies, standards, and services for children and

adolescents.

Psychologists operating within the positivist-empiricist Paradigm I framework would undoubtedly expect that knowledge of effective treatment strategies is the major factor influencing policy development and implementation. The data presented in Tables 1 and 2, however, demonstrate clearly the low priority given Scientific/Professional factors over the recent history of the state's mental health system. Of all the factors mentioned, Scientific/Professional factors ranked at or near the bottom for all groups in both percentage of stakeholders reporting given factors and in the mean number of times each factor was reported. In those few instances where these Scientific/Professional factors were mentioned, the discussion dealt almost exclusively with deinstitutionalization, an issue that has been central to mental health policy for almost 30 years. Related to children and adolescents, this issue took two forms: (a) the need to rely less than has been the case on residential and inpatient-services, whether in the public or private sector; and (b) the application of the "least restrictive" principle to services in the community, with a call for the development of more coordination and communication among the variety of agencies serving children and adolescents in the community, including the need to increase available primary and secondary mental health services.

Of the plethora of mental health interventions developed and written about by psychologists in more recent years, only family therapy was singled out as directly influencing service delivery at the community level. One other theory- and evidence-based intervention was discussed, Project Re-ED (Hobbs, 1979; 1982);

however, it was virtually a negative example in being described as an important and powerful treatment philosophy, which should be, but increasingly hasn't been, an influence on the state's policies and programs for children and youth.

One of our more knowledgeable respondents commented that the mission of mental health systems entails three primary factors: (1) a treatment/scientific/professional complex, (2) political, and (3) economic. If the first of these factors seemed to be relegated in our data to a relatively unimportant place in the hierarchy of factors influencing policy development and implementation, then what is the evidence for the importance of the other two factors, and where do they stand relative to the remaining factors indentified by respondents? The data are clear and highly suggestive: Economic and Political factors were at or near the top for all groups of stakeholders (see Tables 1 and 2).

Representative of many stakeholders' views were comments such as, "Funding in a lot of ways is policy," or "The fiscal policy is the key to everything," or "It's a darn shame, but wherever the dollar incentives are has a lot to do with the direction you're going." Administrators and service providers in community mental health centers also attested to the growing importance of Economics to their organizations. Federal, state, and third-party reimbursement policies were routinely mentioned.

Political factors were next in importance to Economics. Factors such as the relative power of the governor or the state legislature in budgeting and the influence of lobbyists and constituents were commonly mentioned.

Related in many ways to both Economics and Politics--and conceptually distant from the lowest ranked Scientific/Professional factors--Leadership,

Values, and Organizational factors were ranked in the middle and seemed to have modest influence on the state's policy process. Although there was a separate Values category, referring to humanitarian concerns, many of the categories are value laden, and, clearly, the primacy of Economics and Politics manifests an ideological position.

These data illustrate the importance of Economics and Politics in the mental health policy process and underline the need for psychologists to recognize their importance, both in terms of topics and methods of investigation. Many examples exist to demonstrate the inadequacy of the traditional, treatment-focused (Paradigm I) approach to policy inquiry and intervention. Despite theory base, research, and the stated commitment to implement by direct service staff or policy makers, "model" programs and effective treatment strategies have typically not been adopted or implemented--political and economic issues have competed and taken precedence. One example of this conflict and its impact on mental health services to children and adolescents is the aforementioned Project Re-ED, an ecological approach to working with children in the context of their families and communities. An essential component of Re-ED, based on ecological thinking, is the involvement of parents and other significant persons in the treatment of the child, as well as communication with other involved community agencies such as the school or juvenile court. The effectiveness of this approach in both residential and outpatient settings has been recognized, and, in fact, it has been described as one of the most effective approaches in working with children and adolescents (Hobbs, 1982). Yet, as we suggested earlier, respondents mentioned time and

again that Economics and Politics have inhibited the ability of programs to continue the Re-ED approach to treatment. Accrediting bodies and funding sources appear committed to a medical model and individualistic mode of mental health intervention, which, by its typical omission of certain types of services, has discouraged communication with and involvement of parents, significant others, and community agencies. The liaison function--the ecological heart of Re-ED--and needed liaison staff positions are being increasingly ignored and cut off from funds. Similar functions and staff positions throughout the state's child and adolescent system have been cut over the past five years. The effects of such cuts were reported by respondents to be: (a) an increase in the amount of treatment time exclusively devoted to the child and in the length of stay in treatment; (b) a greater likelihood that the child would have to return to some type of treatment in the next several years; and (c) high staff frustration and burn out, leading to problems with continuity of care. The very programs many call for to improve mental health services to children and adolescents (Knitzer, 1982, 1984; President's Commission, 1978; Pecora & Conroyd, 1982) are, in effect, being offered less widely than before in the state under study and across the nation. Rather than the gap narrowing, it appears to be widening.

That political and economic factors influence policy is not new knowledge. Levine and Levine (1970) described the effect of political and economic factors on treatment approaches 15 years ago. Applying their argument in the current context lends some understanding to what is happening in today's mental health system and the hard times that ecologically-based programs such as Re-ED are experiencing. In the present conservative political and economic climate, Levine

and Levine would suggest a turn away from situation-oriented approaches, such as Re-ED, and towards more individual-oriented approaches, such as psychotherapy or traditional inpatient care.

Conclusion

The treatment-oriented positivist-empiricist Paradigm I approach is inadequate for studying, understanding, or influencing the policy process. Our training in clinical and research methods, in general, does not prepare us to transact knowledgeably and effectively with the policy world. If psychologists are to contribute to improving policies and the mental health service delivery system for children and adolescents, we must develop a different conceptual framework by which to guide our thoughts and actions. We propose the consideration of an alternative approach, Paradigm II (Sampson, 1978), to enrich our present positivist-empiricist approach. In contrast to the principles of Paradigm I, Paradigm II holds that: (a) objective facts are not necessarily the only basis for knowledge; (b) theories may not need to be quantitatively verified, a qualitative approach often providing more insight; (c) "truth" is not eternal, but bound to historical and contextual details; and (d) both the inquirer and the policy maker are participants in the process, bringing with them values and ideologies, as do the other stakeholders in the system, therefore, inquiry and intervention are value-laden (Gergen, 1978; Plas & Dokecki, 1982).

In agreement with Sampson (1978), we do not argue that Paradigm II should replace Paradigm I. Rather, like Bakan's (1966) argument for the need to mitigate agency (the individual principle) with communion (the

community principle), we argue for the need to mitigate Paradigm I with Paradigm II. But what might this mean?

Mitigating a positivist with a contextualist approach offers the psychologist both treatment and political/economic foci. The drawbacks of social science solutions (Shadish, 1984) are at least partially avoided by attending to ideological and organizational factors, politically and economically rooted, which influence policy implementation.

Developing mental health standards, then, would involve more than describing a model treatment approach. If the intent is to improve actual service delivery to children and adolescents, treatment issues should be a focus not the focus in the development of the most effective treatment strategies for this population. Further, defining the treatment would not stop with psychological research presenting empirical evidence, but would also include information from the stakeholders involved at all levels of the mental health system, including clients, their families, direct service providers, and administrators. The state we studied has attempted to assess these stakeholder perspectives over the last several years through a planning process that has had varying degrees of success. One problem may be that this process is mostly a Paradigm I endeavor.

Our expanded approach helps psychologists to glimpse the complexity of the system by combining quantitative and qualitative methods for a broader understanding of the desired policy and treatment goals and the means required for their attainment (Fischer, 1980). Attention would be given to (a) the values, missions, and structures of organizations that would provide these

services, (b) funding and reimbursement mechanisms available to cover the cost of care, (c) incentives and disincentives for staff and administrators to provide the treatment as planned, and (d) legal constraints. All these factors and many others will influence the ability to achieve treatment goals.

Focusing on the implementation process as well as the treatment process and its outcomes expands the horizons of psychologists struggling to understand and influence the policy process. What is mandated or planned is not necessarily what occurs at the point of service delivery; some interventions are implemented as planned, many are not--the dynamics of implementation being an integral part of the policy process.

Implementation has received growing attention from policy analysts during recent years (Hargrove, 1975; Mazmanian & Sabatier, 1983). A strategy called backward-mapping (Elmore, 1983) has been recommended as a way to address the needs of the implementing systems. Backward mapping starts from the point of service delivery and works backwards towards administrators and policy makers in an attempt to identify and deal with potential implementation problems, often entailing organizational incentives and capacities.

The traditional policy analysis approach has mostly remained imbedded in Paradigm I. Narrow definitions of outcomes, limited descriptions of organizational variables, and avoidance of value-laden issues have hampered implementation analysis. There is growing recognition by policy analysts and social scientists that this approach is inadequate (Miller, 1984; Reppucci & Sarason, 1979). We suggest the mitigation of Paradigm I with Paradigm II. Qualitative methods and grounded theory (Bogdan & Biklen, 1982; Glaser & Strauss,

1967) need to complement the positivist-empiricist approaches most widely used in policy analysis and program evaluation. This suggestion applies to both the content of the social reality psychologists interested in mental health policy need to explore and to the methods they require to do justice to the complexities they will find in this expanded social reality.

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Table 1

Percentage of Phase One Stakeholders Mentioning Factors Influencing Mental Health Policy

Stakeholder Group	N	Factors						
		Economic	Political	Leadership	Values	Organizational	Legal	Scientific/Professional
Mental Health Department								
Commissioner Level	9	88.9	66.7	44.4	55.6	66.7	44.4	33.3
Staff Level	8	75.0	62.5	37.5	25.0	50.0	50.0	12.5
Other Departments	10	70.0	60.0	60.0	30.0	20.0	10.0	10.0
Instit. and CMHCs	7	71.4	57.1	42.9	00.0	71.4	28.6	14.3
Legislative	8	37.5	62.5	62.5	62.5	12.5	10.0	25.0
Prof. Organ. & Advoc. Gps.	7	85.7	42.9	28.6	71.4	28.6	14.3	00.0
Total	49	79.6	59.2	46.9	40.8	40.8	24.5	16.3

Table 2

Mean Number of Responses by Phase One Stakeholders on Factors Influencing Mental Health Policy

Stakeholder Group	N	Factors						
		Economic	Political	Leadership	Values	Organizational	Legal	Scientific/Professional
Mental Health Department								
Commissioner Level	9	3.22	2.22	0.78	0.67	1.33	1.00	0.67
Staff Level	8	3.00	0.63	0.63	0.38	0.63	0.75	0.13
Other Departments	10	1.90	1.10	1.20	0.40	0.20	0.10	0.20
Instit. and CMHCs	7	3.00	0.57	0.57	0.00	1.00	0.57	0.14
Legislative	8	0.63	1.00	0.88	0.75	0.25	0.00	0.25
Prof. Organ. & Advoc. Gps.	7	2.29	0.57	0.29	0.86	0.29	0.57	0.00
Total	49	2.33	1.06	0.76	0.51	0.61	0.49	0.24